

FILED AUG 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22767

BIRTH NO. 40261-49 REG. DIST. NO. 53 PRIMARY REG. DIST. NO. 3010 Registrar's No. 252

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Cape Girardeau | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Ill b. COUNTY 999 | |
| b. CITY (If outside corporate limits, write RURAL and give town) Cape Girardeau Mo. | | c. CITY (If outside corporate limits, write RURAL and give township) East Peoria | |
| c. LENGTH OF STAY (in this place) 2 days | | d. STREET ADDRESS (If rural, give location) 0 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Francis Hospital | | | |

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|---|--|---------------------------------|--|--|--|---|--|--|--|
| 3. NAME OF DECEASED a. (First) Dennis | | b. (Middle) Wayne | | c. (Last) Hecht | | 4. DATE OF DEATH (Month) (Day) (Year) Aug. 2 1949 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single | | 8. DATE OF BIRTH July 31 1949 | | | |
| 9. AGE (In years last birthday) - | | IF UNDER 1 YEAR 2 Months | | IF UNDER 24 HRS. - Hours - Min. | | 11. BIRTHPLACE (State or foreign country) Cape Girardeau Mo. 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |

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|--|--|--|--|-----------------------------|--|
| 13a. FATHER'S NAME Milton Hecht | | 13b. MOTHER'S MAIDEN NAME Aline Schmidt | | 14. NAME OF HUSBAND OR WIFE | |
|--|--|--|--|-----------------------------|--|

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|---|--|-------------------------------------|--|---|--|---------------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT'S SIGNATURE OR NAME Milton Hecht | | ADDRESS East Peoria ILL. | |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature Infant - 6 1/2 - 7 mos gestation | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | 776X | |

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|------------------------|--|----------------------------------|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
|------------------------|--|----------------------------------|--|--|--|---|--|

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|--|--|--|--|---|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | |
|--|--|--|--|---|--|

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|--|--|--|--|----------------------------|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
|--|--|--|--|----------------------------|--|

22. I hereby certify that I attended the deceased from 8/1, 1949, to 8/2, 1949, that I last saw the deceased alive on 8/2, 1949, and that death occurred at 1. 4000 from the causes and on the date stated above.

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|---|--|---|--|------------------|--|
| 23a. SIGNATURE (Name or title) Chas. J. Herber, M.D. | | 23b. ADDRESS Cape Girardeau, Mo. 63705 | | 23c. DATE SIGNED | |
|---|--|---|--|------------------|--|

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|---|--|------------------------------|--|--|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE Aug. 2 1949 | | 24c. NAME OF CEMETERY OR CREMATORY Lutheran Cenetry | | 24d. LOCATION (City, town, or county) (State) Altenburg Mo | |
|---|--|------------------------------|--|--|--|---|--|

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|--|--|--|--|--|--|-------------------------------|--|
| DATE REC'D BY LOCAL REG. 8-5-49 | | REGISTRAR'S SIGNATURE C. C. Summers | | 25. FUNERAL DIRECTOR'S SIGNATURE Young & Sons | | ADDRESS Peoriaville mo | |
|--|--|--|--|--|--|-------------------------------|--|

RECEIVED 8-8-49
District Health Officer No. 4
District File Number 849-1056
Date Filed _____

This Body was not Embalmed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed *Edward Young*

Licensed Embalmer No. 2138

P. O. Address *Peruville, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.